STATE BOARD OF OPTOMETRY
2450 DEL PASO ROAD, SUITE 105, SACRAMENTO, CA 95834
P (916) 575-7170 F (916) 575-7292 www.optometry .ca.gov

PRINCIPAL PLACE OF PRACTICE ADDRESS NOTIFICATION FOR NEW LICENSEES

Instructions: This form is only for the use of new licensees to notify the Board of their first principal place of practice location. An optometrist's principal place of practice is the practice location to which the optometrist (OPT) license will be issued. There are additional licensing requirements for optometrists practicing at more than one location. The Board's licensing requirements are available at www.optometry.ca.gov. All forms, applications and permits are also available at the Board's website or upon request from the Board office.

Authority: Business and Professions (BPC) Code §3070 requires licensed optometrists to notify the Board of every location at which they practice or intend to practice optometry on a regular basis. BPC Code §3075 requires that optometrists post in each location where he or she practices optometry, in an area that is likely to be seen by all patients who use the office, his or her current license or other evidence of current license status issued by the Board.

Please Print or Type

1. Applicant Information:

Last First Middle OPT License #

Business Phone# Cell# E-mail

2. Principal Place of Practice:

Address City State Zip Code

3. Employer Information:

Please check the appropriate box and provide required additional information if applicable. If there are multiple employers, please provide an attachment to this form. OD, MD, and Department of Managed Health Care (DMHC) license numbers are available on the web at optometry.ca.gov, mbc.ca.gov, and dmhc.ca.gov, respectively. Please note that Kaiser Permanente, Pearle Vision, and EyeExam of California are examples of health care plans licensed by the DMHC.

☐ I am self-employed and own this location.

☐ I am employed by or am an independent contractor for:

_____ _____
Name of Employer(s) OD, MD, or DMHC License #

_____ _____
Name of Employer(s) OD, MD, or DMHC License #

_____ _____
Name of Employer(s) OD, MD, or DMHC License #

4. Declaration:

I certify under penalty of perjury under the laws of the State of California that all the information provided on this form is true and correct and that I understand and agree that any misstatements of material facts herein may be cause for subsequent suspension or revocation of my license to practice optometry in the State of California.

_____ _____
Signature Date